



## TEXAS DEPARTMENT OF INSURANCE

### Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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## MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

### GENERAL INFORMATION

**Requestor Name**

Austin Pain Associates

**Respondent Name**

Texas Mutual Insurance

**MFDR Tracking Number**

M4-16-3397-01

**Carrier's Austin Representative**

Box Number 54

**MFDR Date Received**

July 11, 2016

### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "The insurance carrier has not correctly processed this bill to-date. On appeal, I addressed each denial reason with the carrier and received an almost duplicate upheld denial with no other response from the carrier. In addition, all coding on this bill is aligned with Medicare; however the carrier continues to deny inaccurately stating otherwise."

**Amount in Dispute:** \$1,548.92

### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "Because the requestor's documentation does not support the billing of these codes consistent with the documented place of service, no payment is due."

**Response Submitted by:** Texas Mutual

### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 12, 2015	Urinary Drug Screens	\$1,548.92	\$0.00

### FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
  - P12 – Workers' compensation jurisdictional fee schedule adjustment

- 16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication
- 181 – Procedure code was invalid on the date of service
- 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
- 217 – The value of this procedure is included in the value of another procedure performed on this date
- 225 – The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information
- 612 – No payment is made as Medicare uses another code for reporting and/or payment of this service. Submit corrections W/I 95 days from DOS
- 714 – Accurate coding is essential for reimbursement, CPT/HCPCS billed incorrectly
- 758 – ODG documentation requirements for urine drug testing have not been met
- 790 – This charge was reimbursed in accordance to the Texas Medical fee guidelines
- 892 – Denied in accordance with DWC Rules and/or medical fee guideline including current CPT Code descriptions/instructions.
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly

### Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. Is the respondent's position statement supported?
3. Is the requestor entitled to additional reimbursement?

### Findings

1. The insurance carrier denied disputed services with claim adjustment reason code 892 – “Denied in accordance with DWC rules and/or medical fee guideline including current CPT Code descriptions/instructions.” 28 Texas Administrative Code §134.203(b) states in pertinent part,

For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following:

- (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules.

Review of the submitted medical claim finds the health care provider billed code G0431 and was paid by the carrier. The National Correct Coding Initiative Manual found at,

<https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html>, Chapter 12, Section 12, states in pertinent part,

*HCPCS code G0431 (drug screen... by high complexity test method..., **per patient encounter**) is utilized to report drug urine screening performed by a CLIA high complexity test method. This code is also reported with only one (1) unit of service regardless of the number of drugs screened.*

As the other services in dispute are all for additional drug screenings, pursuant to the above, the insurance carrier's denial reason is supported. Additional reimbursement cannot be recommended.

2. The Respondent's states, "Procedure codes are not billable from the doctor's office per Medicare Fee Guidelines." Per the Medicare Claims Processing Manual, Chapter 16 – 10, states in pertinent part,

*"Diagnostic X-ray, laboratory, and other diagnostic tests, including materials and the services of technicians, are covered under the Medicare program. Some clinical laboratory procedures or tests require Food and Drug Administration (FDA) approval before coverage is provided.*

*A diagnostic laboratory test is considered a laboratory service for billing purposes, regardless of whether it is performed in:*

- *A physician's office, by an independent laboratory;*
- *By a hospital laboratory for its outpatients or nonpatients;*
- *In a rural health clinic; or*
- *In an HMO or Health Care Prepayment Plan (HCPP) for a patient who is not a member.*

The respondent's position statement is not supported and was not considered in the review of this dispute.

3. Pursuant to provisions of Rule 134.203 (b) no additional payment is recommended.

### **Conclusion**

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

### ***ORDER***

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 additional reimbursement for the services in dispute.

### **Authorized Signature**

		August , 2016
Signature	Medical Fee Dispute Resolution Officer	Date

### ***YOUR RIGHT TO APPEAL***

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**